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ANATOMY

IN ITS

RELATIONS TO MEDICINE

AND

SURGERY.

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No. 7.

CRANIAL REGION (continued.)—Behind the auricle, and bounded above by the line where the hair stops, is situated the mastoid part of the lateral region of the head. Its skeleton consists of the mastoid portion of the temporal bone, which is received at this place between the two diverging limbs of the lambdoid suture.

The bone is continued down into a nipple-shaped process, nearly parallel with the cranial centre of gravity. A line drawn from one process to the other will cross the posterior half of the occipital condyles. If a cranium be placed upon a plain surface, the processes and occipital condyles will be found very nearly on a uniform level. Immediately below these processes, in the articulated skeleton, and which can be felt through the soft parts, are the transverse processes of the atlas; and anterior to the processes between them and the styloid processes, are the stylo-mastoid foramina, through which emerge the facial nerves.

The *skin* over this region is moveable, and in delicacy not unlike that of the temple.

The *superficial fascia* is pretty firmly connected to the subjacent parts, contains a very moderate amount of fat, and has lodged in it blood vessels and nerves and lymphatics; beneath it is situated the retrahens muscle of the auricle.

Arteries.—These come from the posterior auricular, and sometimes a small branch from the occipital, neither of which are of any considerable magnitude.

Nerves.—Several twigs are spread over this region, originating from the cervical plexus. They are the *auricularis magnus* and *occipitalis minor*. Two or three small lymphatic glands lie in the fascia, which receive such lymphatic trunks as pass from the head over this part.

Practical Remarks.—Excoriations are frequently seen here in children. These do not follow from any determining organization of the skin. If carefully investigated, such will be found to commence in the auriculo-mastoid groove, where the surfaces rub together, and from thence extend over the other part of the region, either by the irritating nature of the discharge or extension of inflammatory action.

Blisters are frequently applied here in inflammatory affections of the eye. There is no direct vascular connexion rendering the locality specially desirable. The chief advantage would be in the ability to conceal the sores by the hair being combed over. Swellings are very painful from the abundance of nerves and the unyielding base on which they rest, hence the immediate relief following early incisions. As the arteries are small, wounds here are attended with trifling hemorrhage, but their free inosculation with branches supplying the organ of hearing, makes this situation admirably suited for either leeches or counter irritation in inflammatory states of that organ.

The small tumors occurring here in children are enlargements of the lymphatic ganglia, and betoken a scrofulous dyscrasia.

Paralysis of one side of the face follows sometimes a blow over the mastoid prominence from the swelling compressing the main stalk of the facial nerve, where it escapes from the stylo-mastoid foramen. (See fig. 15.)

Attached to the mastoid process are the occipitalis, sterno-cleido-mastoid, splenius and trachelo-mastoid muscles. Their tendons form a very unyielding expansion. The periosteum next in order is very firmly connected to the bone, and is pierced by a large emissary vein, which passes through the bone emptying into the lateral sinus. Very many blood vessels enter the bone at this region.

Practical Remarks.—The musculo-aponeurotic expansion will offer an insurmountable resistance to any purulent collections which may form beneath it, and unless liberated by an incision extending to the bone, would travel downward into the neck. From the direct communication between the integuments and the lateral sinus through the mastoid or emissary vein, the abstraction of blood over this part would relieve directly the intracranial circulation.

The next layer is the bone. Where it is received between the two limbs of the lambdoid suture, a deficiency occasionally exists, filled up by a membrane constituting a fontanelle. In the adult, if the external table be removed, numerous cells are opened, which occupy the whole interior. These are the *mastoid cells*, which communicate with the tympanum.

Practical Remarks.—Through the membranous space already alluded to a portion of the encephalon may protrude, forming a hernia. An abscess in the mastoid cells might be evacuated by removing with a trephine the external wall of bone. In cases where the Eustachian tube is closed, it has been proposed to puncture this mastoid table in order to admit air into the tympanum instead of making an opening through the membrana tympani. Blandin relates the case of Just, physician to the King of Denmark, who lost his life from this operation being followed by erysipelas, though this result should have little weight in preventing its repetition where a case seemed to indicate its employment, as it might follow from any very slight injury to the scalp. The space existing between the two osseous layers of the mastoid part of the temporal bone will admit of great depression without producing any compression of the cranial contents. As the consequences of scarlet fever are often so destructive to the organ of hearing by inflammation extending into these passages would not counter irritation practiced early over this region in all cases of the severe forms of the disease, exert a salutary prophylactic influence by forestalling the tendency?

Cranial Bones.—As there are accidents affecting the continuity of the bones of the cranium, I may proceed to state a few facts in its mechanism, which will, in a majority of cases, determine the seat of injury. The influence of form, articulation, composition, groinings, &c., have already, in a former paper, been sufficiently insisted upon. Fractures will occur either in the vault or the base, or may extend from one to the other. When they occur at a point distant from the applied violence, they are said to be produced by *contre-coup*.[1]

Fractures in the Vault.—With a view to illustration, the cranium may be considered as consisting of two arches, with their bases applied to each other, on a level with a section passing through the walls just above the superciliary ridges in front, and the occipital protuberance behind. The summit of the upper arch will be the saggital or interparietal suture, that of the lower will be the middle of the base. Fractures which involve the upper arch will be likely to occur at the two extremes, or the summit. If a force be applied on the forehead, and there be no resistance but the inertia of matter, the fracture will most probably be at the point of application. If, however, at the time such force is received, the head should be against some immovable obstacle, then the force and resistance being equal,

[1] For the study of this subject, a head with the calvaria removed should be obtained.

the fracture might be expected to take place at both points, or inasmuch as the blow and counter blow tend to shorten the base by approximating the extremes of the arch, it may occur at the vertex, midway between the two. Viewing this superior arch laterally, it might be supposed that fissure from violence on the top of the head would occur at the upper part of the temples; this is, in a great measure, prevented by the temporal ridges, but is liable to take place below in the squamous part of the bone, because in this part it is well nigh altogether formed of compact tissue.

Fracture in the base.—To properly appreciate this subject, let the reader take a skull, and remove first the vault, and then the bones of the face. If it be now examined on its cerebral surface, three fossæ or terraces appear, related to each other as anterior, middle and posterior. In the same order they sink one below the plane of the other. The first is over the orbits, supports the anterior lobes of the cerebrum, and is divided into symmetrical halves by the interposition of the ethmoid bone, to the crista gallæ of which is attached the falx major, and on the cribriform plates of which rest the bulbs of the olfactory nerves, and the nasal branches of the fifth pair. These plates form a part also of the roof of the nasal cavities.

Practical Remarks. — A fracture which penetrates this anterior fossa will be characterized by leakage into the orbit with infiltration of the submucous tissue of the eyes and eyelids, with discharge of blood into the nose, and may affect the smell or the common sensibility of the nose by disturbing the olfactory lobes or nasal nerves.

Middle Fossa.—This terrace is over the pharynx, supports the middle cerebral lobes, and is separated also into two halves by the body of the sphenoid bone, which presents an olivary process for the optic commissure, and a sella turcica for the pituitary body and circular sinus. On either side are numerous foramina, through which pass the optic nerves and ophthalmic arteries, the third, fourth, ophthalmic division of the fifth, and the sixth pairs of nerves, together with the ophthalmic veins, the superior and inferior maxillary nerves, and great meningeal arteries. The cavernous sinuses and internal carotid arteries occupy a groove on each side of the body of the sphenoid bone.

Practical remarks.—Fractures affecting this fossa may therefore be attended with impairment of vision, rupture of a sinus, hemorrhage into the pharynx, or from the nose—if through the body of the sphenoid, the cells of which communicate with the nasal fossæ—disorder of sensibility in the parts supplied by the fifth pair, paralysis of the muscles of mastication, which are endowed from the motor root of the same pair of nerves, (fifth,) paralysis of the muscles of the eyeball, supplied from the 3d, 4th and 6th pairs, lesion of the carotid or meningeal vessels, etc.

Posterior Fossa.—This terrace is over and behind the spinal canal, and sustains the two hemispheres of the cerebellum. The basilar process, occipital foramen, and lower arm of the occipital cross separate it into two halves likewise, and in the same order they accommodate the medulla oblongata, medulla spinalis, with its membranes, the vertebral blood vessels, spinal accessory nerves and occipital sinuses. On either side of these central structures are grooves for the lateral and inferior petrosal sinuses and openings for the hypoglossal nerves, (anterior condyloid foraminæ,) also for the auditory and facial nerves, (meatus auditorius internus,) and 8th pair, (jugular foraminæ.)

Practical remarks.—Fractures passing into this fossa may be followed, by derangement of deglutition, or respiration, from injury to the medulla oblongata; irregularities in muscular movement; paralysis of the extremities by implicating the spinal marrow; of the tongue, from injury to the hypoglossal nerves, or the face from injury to the facial, or the hearing from accident to the auditory, and various anomalous phenomena in the sense of taste through the glosso-pharyngeal, in the voice, action of the heart, lungs, and functions of the

abdominal viscera through the pneumogastric nerves, and finally to the sinuses.

Fracture at the Base.—Now what circumstances in the association of the cranial bones are there, which necessitate in a great measure the locality, and direction of a fracture at the base? While the differences in these bones are most apparent, yet, when all the modifying influences of structure and connection are summed up, the principle of compensation is so equally adjusted, that if there was one point on the vault equidistant from a given point at the base, vibrations excited among the atoms of the cranium at the former would reach nearly at the same time the latter, hence when any force is applied to the head the resulting momentum will be conducted to the base by the shortest route. If the cranium be considered an arch the two ends of the span antero-posterior (that is the frontal bone in front, and the basilar process of the occipital behind) will rest against and be seperated only by the interposition of the sphenoid bone. Examined in a lateral view the same is in a great measure true, the arch from side to side is supported by the sphenoid bone.

Now to practically apply this observation, a force coming in contact with the head not further back than the coronal suture would reach the base from both arches in the middle cerebral fossa, and if a solution in the continuity of the bones occur at all it will most probably be in this fossa.

But suppose the violence be received above the root of the nose at the lower part of the forehead, what particular points of resistance are provided? On either side are placed strong abutments in the malar bones which are propped against the external angular processes of the frontal, and behind the wings of the sphenoid bones, and as a consequence of these defences the fracture will be determined between the two, which would direct it through the roof of the orbits or into the anterior fossa.

Again if the force be inflicted at the posterior part of the parietal bones or upper portion of the occipital, travelling by the shortest way towards the base, it will enter the posterior fossa where the fracture will take place.

The posterior and middle fossæ are separated by the petrous part of the temporal bone. The apex of this bone rests against the basilar process of the occipital, so that when violence is received on the lower part of the back of the head it will be delivered upon its extremity, and the break will be transverse or at right angles to its long axis opening therefore the two fossæ into one, and involving in some degree or other the two petrosal sinuses, the internal carotid artery and the seventh pair of nerves.

In front of the petrous is the squamous part of the temporal bone which rests against the wing and spinous process of the sphenoid, so that if a blow be implanted on the side of the head, on, above, or behind the ear, the resistance being at the summit of the petrous and inner edge of the squamous portion, the fissure will be between the two or in the direction of its long axis.

Case of Perocephalus, and Concretions of Phosphate of Lime in the Placenta.

By W. Spillman, M. D.,
Of Columbus, Mississippi.

On the 27th of May, 1854, I was called in to see a well formed robust mulatto woman; found her in labor, second confinement. Was informed that her first confinement took place in March, 1853, her age at that time being about 18. Was also informed that she was delivered (still-born) on the third day, and that the child was literally covered with small blisters. On an examination per vaginam, found the os tincæ well dilated, membranes protruded and considerably distended. In an hour or two the membranes ruptured, and a considerable amount of liquor amnii was discharged. Another examination was then made, and to my astonishment, I could only discover what appeared to be a spherical coreaceous membrane, filled with a fluid, but too large to pass the brim of the pelvis, and only slightly protruding during the time of a pain. After some time I was able to discover what appeared to be the edges of loose bones, that shifted their position in the fluid mass, which led me to suppose that it was a case of hydrocephalus. As soon as I was satisfied that the

presentation was that of a malformed and much enlarged head, I proceeded to administer chloroform, and made an incision in the scalp with a pointed bistoury; (being seven miles in the country and having no instruments with me but a pocketcase). As soon as the incision was made there was a sudden gush of over a quart of blood intermixed with a portion of the brain in a ramollissement condition: after which the delivery was immediately completed, the contraction of the uterus continuing even when the patient was under the influence of chloroform.

Condition of the child. Body and limbs of full size, normal as far as observed, except numerous blisters filled with a limpid yellowish fluid. Frontal, temporal, and parietal bones imperfect; parietal bones without any attachment. Placenta very large, containing a number of concretions of phosphate of lime, resembling scales or spiculæ of bones. The tunica at its attachment with the placenta was involved in an indurated abscess, together with a concretion nearly as large as a finger nail. I still have the placenta preserved in alcohol.

On the 27th of August, 1855, I was again called in to the same woman, found her in labor, pains feeble, no evidence of life in the fœtus.

28th. Condition about the same, prescribed a dose of castor oil.

29th. Pains more active, liquor amnii discharged. Presentation right shoulder; as the woman was threatened with severe hæmorrhage, I administered a dose of ergot, and at once proceeded (after determining that the head was not too large,) to turn and deliver by the feet. Child still-born; normal as far as could be observed, except like the previous cases, covered with blisters, filled with a yellowish fluid. Placenta normal. In each of the above named confinements, the woman did well, recovering her strength in a short time.

Her fourth confinement took place in the summer of 1857; she was not delivered until the ninth day after labor commenced, and as previously the child was *still-born;* the third day after, the woman died. Particulars not known.

After the third confinement of this woman, I obtained from her the following account. That her health had always been good; never had any symptoms of gonorrhœa or syphilis; (this was also corroborated by her owner, Mrs. B.,) that the father of her first child was a white man, and with whom she had frequent intercourse. (*This man to my own knowledge had suffered considerably with both gonorrhœa and syphilis;*) that after her first confinement she married a black man, who as she stated was the father of her subsequent children.

Query.—Could an abnormal condition of the uterus in this case have been produced by the vitiated semen of the father of the first child of this woman?

The mother of the woman under consideration is a light mulatto, her father a black negro, both of whom are still living, and quite healthy.

Illustrations of Hospital Practice.

PENNSYLVANIA HOSPITAL.

Service of Dr. Levick.

MAY 21ST.

Pleurisy and Phthisis.—A pale, thin, cadaverous looking man. Some months ago he was seized with a sharp pain in the left chest, and at the same time he complained of a slight cough. There has been but little expectoration. In addition to these symptoms there has been a loss in his weight of at least 22 pounds since the onset of his disease.

Upon measuring the two sides comparatively, there is found to be about an inch difference. The side that is the largest gives decided dullness upon percussion, and little or no respiratory sound can be heard.

There is no question as to there being pleuritic effusion in the left chest. The effusion is considerable in amount; if there were but a slight collection of fluid in the pleural cavity, the vocal resonance might be so modified as to produce *egophony*, that peculiar sound of the voice produced by its passing from a lung partially compressed by a liquid.

Yesterday there was a crackling heard at the upper portion of the lung, and this, taken in connection with the feeble respiration, leads to a very serious diagnosis.

There is also an interruption to the entrance of air into the pulmonary vesicles, giving rise to a peculiar jerking inspiration; this indicates the existence of some obstacle to the respiration, and this obstacle is the result of tuberculous deposition.

Pleurisy, not unfrequently, is due to the presence of tubercles on the pleural surface, a fact we should carefully bear in mind when prescribing for any case, as mercury, which is recommended so highly in ordinary pleuritic effusion, would be strongly contra-indicated if the disease were of tuberculous origin.

Treatment.—Cod liver oil and the iodide of potassium.

[The rationale of the action of these medicines we have frequently given.—REPORTER.]

After showing a large number of cases of phthisis in various stages of the disease, the following case of *Bronchitis* was brought forward to illustrate the difficulty often attending the diagnosis of chest affections:

A German, aged 26 years, a machinist, was exposed in a storm two years ago, since which time he he has suffered more or less with cough, was admitted into the Hospital three months since. He now has the general appearance of one suffering from a protracted disease; is somewhat emaciated, and harassed by an obstinate cough, which has refused to yield to the usual remedies. Upon examining his chest, we hear sonorous and sibilant rales throughout the lungs, mixed with occasional subcrepitant rales, these last being comparatively slight. There is no evidence of a large cavity, or indeed any physical sign which could not be explained by the existence of simple bronchitis. And yet so intractable has been the disease, that I have no doubt that there exist throughout the lungs myriads of minute tubercles. Percussion elicits much the same sound on either side; no marked dullness, but rather less clear than is usual in healthy chests. The man has had for a long time very troublesome hectic fever, which is not proportionate to the condition of his lungs. We must seek elsewhere for the cause of this. Doing so, we find that there is pain in voiding urine, and under the microscope this is seen to be crowded with pus corpuscles. Deep pressure over the regien of the kidneys produces pain. There is at times delirium, with headache. What, then, is the condition we have here? I believe there is a general, tuberculous diathesis existing, that the cough and bronchitis are kept up by the presence of minute miliary tubercles; that the hectic fever is in part due to this, but still more to the abscesses existing in the kidneys, as shown by the highly purulent condition of the urine; that these abscesses are of a tuberculous or scrofulous character; that, though the bladder may be somewhat affected, the kidneys are more so, as shown by their tenderness on pressure, and that the headache and delirium are due either to the condition of the blood imperfectly depurated, or a tuberculous condition of the brain, or, as is most probably the case, to both.

Such being our diagnosis, we have placed him on the use of cod-liver oil, a cough mixture containing the acetate of morphia and syrup of wild cherry bark, and highly nutritious diet, counter irritants being applied to the chest. He has derived much relief from the irritation produced by the scalding of his urine by the use of a mixture consisting of *a wineglassful of infusion of buchu, half a teaspoonful tincture of hyoscyamus*, and *ten drops of liquor potassæ*. You will find in some of the journals that the association of liquor potassæ and the narcotic extracts renders the latter inert. I do not believe it, having very often seen the happiest results follow the use of the mixture I have mentioned.

Dr. L. again called the attention of the class to the difficulty of deciding from the physical signs alone between simple chronic bronchitis and that of miliary tubercle, and bade them always bear in mind the probable existence of phthisis in cases of diffused bronchitis, especially if occurring in young persons, which did not yield to proper treatment.

Aneurism of the Subclavian Artery.—An interesting case for diagnosis was afforded in this patient. A strong, healthy, well-developed seaman, aged 30 years, was admitted into the Hospital, complaining of pain in the *right* shoulder, which he supposed was of rheumatic origin. There was no cough, no dyspnœa, no difficulty of any kind other than a gradual loss of strength, and pain in the part indicated. In carefully investigating the cause of this pain, the hand was placed on the opposite shoulder, and the artery of the two sides compared, when there was discovered to exist beneath the *left* clavicle a very strong characteristic thrill, accompanied with the harsh, rough murmur of aneurism.

Dr. L. having compared this with the aneuric thrill sometimes found in cases of phthisis, called the attention of the class to the lesson taught by this case, never to rest satisfied with a partial examination in investigating disease.

Rheumatism.—This case has been already alluded to. It was an instance of acute rheumatism, there co-existing a slight systolic murmur.

The case is now brought forward to show the effect of treatment. The patient, after taking a mercurial cathartic, was placed upon the use of the phosphate of ammonia in doses of 16 grains four times a day.

He has used the ammoniacal salt during seven to

nine days, with the effect of almost completely removing the disease.

This remedy, introduced by Dr. Buckler, of Baltimore, about twelve years ago, was much used in the hospital at that time, and with satisfactory results. Like many other medicines, it is not so much in vogue now as it was at first; but Dr. L. remarked he had derived much benefit from its use in numerous cases of rheumatism during the present and previous terms of service in the hospital.

Dropsy Consequent on Cirrhosis.—I doubt whether you are able to recognize the man who now walks into the arena. When last before you, his abdomen measured in circumference 42 inches; it now measures but 31. The swelling of the feet has disappeared entirely.

The treatment consisted in the administration of an active purge, the compound powder of jalap, and then the continuous use of the bitartrate of potassa.

When admitted into the hospital it was impossible, in consequence of the ascites, to feel the edge of the liver, but now the outlines of the organ can be distinctly felt through the abdominal parietes. We thus confirm, by the sense of touch, what by process of induction and exclusion we had formerly designated as the cause of his dropsy, viz. disease of the liver.

It is very desirable to remove, if we can, not merely the dropsy, which, as you have been told, is but a symptom, but the cause producing it. We might, perhaps, derive some benefit from mercurials, but I prefer here the preparations of iodine, and the man at present is using the iodide of potassium, the ointment of iodine being at the same time externally applied.

Gangrene of the Lungs.—Has been frequently before the class. The patient now looks like a man in perfect health, his cheeks are assuming a reddish tint, and his weight increasing.

The treatment pursued was of the most supporting and stimulating character. The lower side of the left lung gives a flat sound upon percussion, and as might be anticipated, ausculation gives an increased resonance of the voice, and coarse mucous rales may still be heard, showing that though these general symptoms have very much improved, there is still left very serious local disorganization, rendering it unsafe for the patient to resume his usual occupations, which he is anxious to do.

He is still using cod liver oil and Huxham's tincture of bark, and highly nourishing food.

Tuberculosis—Laryngitis—Tracheotomy—About a week ago Dr. L. introduced to the class a young woman who was laboring under tuberculous disease both of the lungs and larynx. The voice was almost entirely extinguished, and the respiration very laborious, in consequence of the ulcerated and swollen condition of the lining membrane of the air passage.

Yesterday morning, about 6 o'clock, Dr. James H. Hutchinson, Resident Physician to the hospital, was suddenly called to the patient, in consequence of the increasing dyspnea. She was almost moribund, the countenance livid, and the respiration almost completely suspended. In a few minutes, according to all human reason, she would have died.

Dr. Hutchinson at once resorted to the operation of tracheotomy, with the happy result of affording instant relief to the poor sufferer.

The operation was performed in the usual way, and a double canula introduced into the opening.

At the time of our last visit to the hospital, this patient was walking about, apparently in better health than she has for some time enjoyed.

Rheumatism—Propylamine.—A middle aged woman has had rheumatism during the last ten days; joints much swollen, and marked evidences of endocarditis.

Attention is particularly called to this case from the fact that Dr. L. directed her to be placed upon the use of propylamine, of late highly spoken of in arthritic affections.

Propylamine is a peculiar substance extracted from herring pickle, and also ergot and nicotine, when acted upon by potassa. It has the peculiar odor of herring pickle. Alkaloid properties are attributed to this substance.

The dose is two drops every three hours in mint water. She has been using it in doses of two drops every three hours, and says she is decidedly better, but it would be improper to form any opinion as to the value of the remedy until it has been further tested.

Service of Dr. Neill.

MAY 21ST, 1859.

[*Continued from last week.*]

Tetanus following Laceration of the Hand.—I present this black man as a matter of duty, to show you some unfortunate results of surgical experience. If I were not to show you the dark side as well as the bright, you would receive wrong impressions of practice. This patient has tetanus.

This is an affection of the spinal marrow, generally traumatic, although it may be idiopathic. It is generally supposed to result from recent injury of the nerves, but this is not invariably the case. I have seen it result, in three or four cases, from granulating surfaces. This case is traumatic: from

a local origin, it is transferred to the spinal nervous centre, and radiated to the extremities.

There is a disposition in this patient to throw the head backward, caused by contraction of the muscles of the back, and termed opisthotonos, sometimes manifested to such an extreme degree that the patient rests upon his heels and his occiput.

But this is not the most common manifestation of this disease. More frequently it is first observed in the sterno-cleido-mastoid, then in the jaw, face, and recti-muscles of the abdomen, which will exhibit the *lineæ transversæ* very distinctly. After a while those muscles become involved which are engaged in vital processes, the sphincters, etc., hence the constipation.

The *prognosis* in young persons is more favorable than in adults. I have seen three boys walk about on their toes after they had recovered from tetanus

The principles of *treatment* are, the avoidance of exposure of wounds to drafts of air as a preventive. I must caution you against dressing stumps before open windows, even in warm weather, when the wind is blowing. Besides this, the points are three —nourishment, stimulants, and opium, or analagous remedies. The patient must be quieted as much as possible; and here I may say, that anæsthesia by ether has not been attended with particularly gratifying results.

All constriction has been removed from the limb, and a poultice applied. There has been an idea, that while a wound suppurated, tetanus could not occur. This is not true. Tetanus will occur after suppuration is fully established; but when tetanus does occur in such cases, suppuration is diminished and the wound has a tendency to become dry.

I am inclined to think that this arose from the original injury. If so, amputation would have been of no avail. If you cut off the limb you will not get rid of the tetanus; for it is a disease not of the extremity, but of the spinal marrow.

The man was placed upon beef tea, milk punch, and large doses of opium. The tetanic rigidity increased, and he died on the 23d. He had no severe paroxysms or convulsions.

Operation for Staphyloma, the result of Burns.—Dr. Neill remarked that the affection in this case might be looked upon as a painful cicatrix of the cornea, involving the iris. The patient had been severely burned by flame, and had lost the sight of this eye. The cornea was prominent, and a portion of the iris was involved in the cicatrix. A sympathetic affection of the sound eye was often caused by a diseased iris in the other. He has had excruciating pain over the brow.

It was proposed to excise a portion of the cornea. Dr. N. took this opportunity to give directions as to how the assistant should hold the eyelid in any operation on the eye, for the want of which a surgeon is often greatly embarrassed by eversion of the eyelids. The finger should be placed on the approximating edge of the tarsal cartilage, holding the eyelashes and their roots beneath the grasp. This brought the lid under complete control.

He never used an instrument to hold the lids, but relied on a competent assistant. In this instance, it being the right eye, he held the upper lid and the assistant the lower.

A cataract knife was introduced near the upper edge of the cornea, and a large flap cut from below, the remainder was separated by a pair of scissors. Wet lint was applied.

Operation—Cataract.—The patient was a gray-haired negro man; the cataract in the left eye, very complete, irregular; not homogeneous; resembling spermaceti or camphor.

Cataract is an opacity of the crystaline lens, and should not be mistaken for other diseases of the eye. It is manifest by both physical and rational signs.

If you examine this man with care as he walks before you, you will see the opaque lens behind the pupil which has been dilated with solution of atropia. The sight of the other eye is slowly obscuring, this lens has a central opaque nucleus. If an old man has one good eye, it is sufficient for him, and it is a rule good in other cases; if one eye is good, let the other alone.

Of the three operations—extraction, reclination or couching, and solution—the latter is the most advisable. The capsule and the lens would be broken by a needle, and he would trust to absorption for the removal of the cataract.

Light dressings were applied, and the patient directed to be confined in a dark room.

MAY 25TH.

Falls from a great height—Various Effects.—Recent Specimens—Brain and Liver.—These were obtained from a patient who died shortly after his admission. He fell from a great height, and received a fracture of the skull, extending through its base. Hemorrhage occurred from the ears.

This brain is surcharged with blood, and there is infiltration of blood, or ecchymosis through the vesicular structure of the inferior portion of the anterior lobes of the cerebrum.

There is also a rent in the upper portion of the right lobe of the liver.

Injuries from Falls.—Case 1st. This patient fell from a third story window, without very serious injury. His color, temperature and expression are good. We examine his pulse, to see if there has

been any great shock to the system; it is normal here. There is evidently no injury to the brain or skull. He is bruised, and complains of pain over the chest. If there were injury to any viscus, there would be prostration; if rupture of the bowels, tympanitis; if effusion of blood, we could detect it by percussion.

It is not impossible that he has bending and bruising of the costal cartilages, which will cause as much pain and inconvenience as fracture of the ribs; no crepitus can be detected.

He will be treated as with fracture of the ribs—rest, and adhesive strips around the affected side, from the sternum to the spinal column.

Case 2d. A lad, who had fallen four stories, walked into the amphitheatre. No bones were broken, and, except some lameness of the ankle and general soreness, no injury sustained; partly perhaps from the cartilaginous condition of the skeleton, and partly from good luck. There was no reason why one should be killed by such a fall, and another escape unhurt.

Case 3d. A young man, just brought into the house, fell through a bridge an hour ago. He was still suffering from the shock of the injury. His pallid countenance and blanched lips, extremely feeble and flickering pulse, labored and spasmodic respiration, were those of a person in a moribund condition.

Consciousness was not destroyed. There was a fracture of the frontal bone, probably extending into the orbital process, producing great ecchymosis of the eyelid and orbit. The fracture probably extended to the base. There was emphysema over the chest, and great irregularity of the sternum.

The *prognosis* was unfavorable.

Mustard poultices would be applied to his body, and dry heat; dry heat was stimulating, wet heat relaxing.

(The patient died shortly after, and a post mortem examination confirmed the diagnosis of the extent of fracture of the skull; both the temporal bones, and the sphenoid were fractured; he also had fracture of five ribs, and laceration of the lung.)

—o—

W. Ottenbourg informs the Medical Society of Paris, that observation has led him to the conclusion, that permanent enlargement of the tonsils protects against croup. Children, exposed to the infection of croup, having enlarged tonsils, escaped the disease, while others without hypertrophy of these organs contracted croup. (?)

Medical Societies.

NORTHERN MEDICAL ASSOCIATION.

FRIDAY EVENING, FEBRUARY 11TH, 1859.

Dr. Curtis, (President,) in the Chair.

By request of many members, the subject of DYSENTERY was resumed from a former meeting.

DR. WITTIG had employed the nitrate of sodium, in several instances, but never where much fever was present. He afterwards used opium with emulgents, combined with almond oil, or oleum papaveris.

DR. RHEIN had never considered this disease to be one in which we had great fever. We generally find the skin cool, the pulse small, though frequent, and all those symptoms which would contraindicate the employment of acute febrifuge remedies. In the treatment, it might be necessary to employ purgatives, but he never used them to any great extent, and especially would he feel doubtful about the use of drastics. His prescriptions, were as a general rule, composed of calomel, opium, and ipecac., increasing or diminishing each, according to circumstances. Generally, when called early, he gave calomel, but when it has produced bilious discharges, its good effects are passed; it then stimulates the bowels, and causes too free a peristaltic action, and hence he omitted it, as soon as possible. When the bowels were checked, he considered the patient well, and not requiring any further medication. He had often used Hope's mixture, but never with good effect.

DR. GEBHARD, from the remarks of Dr. Rhein, would regard the cases he had mentioned as chronic dysentery, whilst his own were acute, with fever, etc. He preferred *active* purgatives rather than those of a milder nature. When it assumed a chronic form, the treatment, as given by him in the paper read at a former meeting, would not be so applicable.

DR. RHEIN remarked that his preceptor, in the large number of cases of this disease which he has attended near Reading frequently employed a combination as follows:

R. Liq. sodæ carb. (sat.) ℥iv.
Ol. ricini, ℥ij.

Ft. mist.

Dose: a tablespoonful every 2 hours.

This was continued until the patient had taken it about eight hours, by which time, as a general rule, he was convalescent. Dr. R. had used this himself, and with apparent success, but in the course of practice, he had given up this plan, and now generally employed opium, calomel, and ipecac., as before mentioned.

DR PRICE considered that the great cause of this dysentery is an exposure to cold, at a time when the body is heated. This produces a tendency of the fluids to the internal organs, congestion follows, and is not unfrequently succeeded by dysentery.

Perhaps the nitrate of potassa, as employed by Dr. Tiedeman, acts not only as a purgative, but also as a sedative, thus relieving the spasmodic constriction of the bowels, and the inflammation at the same time. He did not agree entirely with Dr. Gebhard in regard to drastics, as he thought them rarely necessary. He regarded calomel as the best of the class of purgatives that we can employ, because the liver is the great point we have to attack; it being efficiently acted upon, the congestion of the portal circle, which is one of the most important causes of trouble, is thus removed. Opium allays the irritability, and acts equally well upon the skin, which is especially desirable.

In the last stages, there is nothing better than oleum terebinthinæ, which Dr. P. had used with an eminently beneficial result. It is superior to everything else.

DR. GEBHARD believed that these drastics lose their peculiar effects, and only produce copious evacuations, the tenesmus ceasing quickly. He thought it could be accounted for, on the principle that the peristaltic motion is increased, and expels the cause of the disease. When the tenesmus returns, as it sometimes does, the cause not being entirely removed, we may repeat the dose if the system will bear it. To children, he gave castor oil, with decided advantage, it acts like a charm. He rarely found opium necessary, except after the patient had continued to have evacuations, and required rest from the irritation. Previous to the adoption of this plan, he had used opium, and found the cases much protracted, and the danger increased.

DR. OSLER believed that recovery often takes place, and convalescence still more frequently, without any such fœcal dejections as must necessarily precede recovery, if the theory on which Dr. Gebhard bases his treatment be correct.

The good effects of the purgatives so highly recommended, were mainly due, he believed, to their action on the liver. Other articles equally efficient as purgatives, but incapable of a similar action on the hepatic function, would be very likely to prove inefficient, if not positively injurious. But while dissenting from the views of Dr. G. concerning the etiology of dysentery, he was not prepared to say that the treatment he proposed might not prove, in a majority of cases, and especially in the early stages of the disease, highly serviceable.

He had in several cases derived very satisfactory results from the treatment proposed by Dr. Tiedeman. He gave the nitrate of potassa in doses of from 10 to 15 grains, and also used the cold water injections. He was particularly pleased with the soothing effect of the cold water. But however applicable to a majority of cases, no enlightened physician will pretend that either the nitrate of potassa or the purgatives so highly recommended this evening, are specifics.

The treatment of dysentery must vary with the varying complications and peculiarities of different cases. Complications can readily be thought of which would render necessary other means than those under discussion.

There are two articles, not enumerated by any authority, that he could then recollect, among the reliable remedies for dysentery, which he was prepared, after thoroughly testing them during a period of several years, to say were worthy of the special attention of the Association. These were sulphur and chloride of lime.

It was not in ordinary cases merely that these two articles had proved effectual. Several of the gravest and most intractable he ever attended, after resisting all the ordinary appliances, promptly yielding under their use.

He commences the treatment with both articles, but generally discontinues the sulphur after a few fœcal evacuations have been procured, which mostly occurs by the third day, at which time the patient is frequently convalescent. From 10 grs. to ʒj. of the sulphur constitutes the dose. The chloride of lime he gives in doses of 5 grs. in a teaspoonful of water every four or six hours. The disagreeable taste of the lime is best disguised by milk, well sweetened with sugar.

Opium, though not an essential part of the treatment, contributes greatly, in many cases, to the comfort of the patient. It is impossible to give the chloride of lime in some instances on account of its extremely disagreeable taste. That was his principal reason for having recourse on some occasions to other remedies. Leeching the anus is an efficient means of relief at the commencement of an attack, and the warm bath at a later stage is equally efficacious. Wormseed oil he had found in the few instances in which he had been able to prevail on patients to take it, a remedy of great value, especially in cases of children.

DR. PRICE, in reply to a question as to what he meant by congestion, said in congestion we have merely an afflux of blood to the parts without lesion of any organ or tissue, but in inflammation we have in addition to this a derangement of the organic structure as an indispensable accompaniment.

Now, dysentery is an inflammation of the mucous membrane of the rectum and colon. He would explain further, that the capillaries *between* the colon

and liver might be congested, while those *at* the colon are inflamed.

He did not think that the other methods of treatment contra-indicated the use of purgatives. The nitrate of potassa, as employed by Dr. Tiedeman, produces alvine evacuations, and should it fail, he counselled the use of castor oil. It is absolutely necessary to remove the spasmodic action by some means, hence the beneficial effects of the treatment so strongly insisted upon.

Dr. Rhein thought the speakers had confounded inflammation with congestion. If there was congestion, purgatives *might* be good, but if inflammation, they certainly must be mischievous. A surgeon puts an inflamed joint on a splint to place it at rest; he does not move it about violently. If an eye is irritated, we deplete and place it in a state of rest: on the same principle, the remedies mentioned, in place of relieving, would, by increasing the peristaltic action, increase the tormina and tenesmus. He mentioned the case of a child, to illustrate this point. The mother, under the popular notion of a purgative in dysentery, had given it castor oil, with laudanum, and was surprised to find it no better; the disease still persisted, till at last he, being called in, gave opium, and the child recovered. The first indication is to relieve the pain; and this holds good in all diseases. Relieve the pain, and you relieve the disease.

Dr. J. R. Bryan said that cases vary much, and hence we must vary the treatment. The chief indication is to stop the discharge, and therefore if the bowels have been evacuated, as they generally have been, we must employ anodynes, or astringents, etc. His favorite was Hope's mixture. He also used turpentine, with paregoric on sugar, in small doses. Cases have many different features. He mentioned the case of a delicate woman who had frequent attacks, after obstinate constipation. She had 60 evacuations in 24 hours, all of blood and slime, and was much exhausted. On examination, he found in the left iliac region, an enormous tumor. He thought the only thing he could do, was to give a very active purgative, and therefore gave her small doses of croton oil, in mucilage. To his surprise, she passed an *enormous* quantity of feculent matters, which had been causing all the trouble.

In reply to a question of Dr. Rhein, as to whether he considered it an inflammatory disease, he said that as a general rule he had not seen fever with it, and hence did not consider it inflammatory. He always inquired as to the nature of the discharge, and took care not to be deceived, as is often the case, by patients supposing what little they have passed to be a copious evacuation.

Dr. Curtis was in the habit of using the opium treatment; Dover's powder, with a little calomel and aromatic powders. Had given 2 grains and more of opium at a time, to relieve such cases. He was inclined to look with favor upon the plan of Dr. Gebhard. He had lately seen a case, which had changed his views somewhat. The patient had taken opium, and the evacuations were in a degree arrested, but still slime and blood were passed, and the case would not improve. He gave a purgative, and the effect was instantaneous. The discharge was checked, the pains gone, and all the symptoms were much improved. There is a tendency to health in all diseases, and if we assist nature thus, she will cure herself. He considered this disease an inflammation of the bowels; we must get rid of the cause, and put the alimentary canal at rest. Strychnia improves the symptoms, by relieving the tenesmus, and some physicians use it freely. His first desire was to relieve the bowels.

Dr. Rhein was inclined to take a different view. He regarded the feces as a *poultice;* a protection to the parts from the irritating discharges. Clear out the bowels, and we give this irritating matter a fair chance to act.

Adjourned.

Reviews and Book Notices.

Elements of Medicine; *A Compendious View of Pathology and Therapeutics; or, The History and Treatment of Diseases.* By Sam'l Henry Dickson, M. D., LL. D., Prof. of the Practice of Physic in Jefferson Medical College, Philadelphia, etc., etc. *Second edition*, revised. pp. 768. Philadelphia: Blanchard & Lea, 1859. *Price* $3 75.

We welcome this new and improved edition of Dr. Dickson's Elements of Medicine. The first edition was so well received by the profession, that we anticipate for the present one, in its enlarged and improved form, a rapid sale. Dr. Dickson is a perspicuous writer, and he has presented his subjects to the practitioner and student in a comprehensive and pleasing manner.

The author being a southern man, and having been engaged in teaching medicine for more than thirty years, principally at the South, his work is particularly valuable to the southern practitioner, as containing the experience and observations of an intelligent man on diseases prevalent in that section of country. It will be a valuable addition to the library of every medical man.

The paper, the printing, and the binding are particularly good, and do credit to the good taste and liberality of the publishers.

FIVE ESSAYS. By JOHN KEARSLEY MITCHELL, M.D., late Professor of the Practice of Medicine in Jefferson Medical College, Philadelphia, etc., etc. Edited by S. WEIR MITCHELL, M. D., Lecturer on Physiology, etc., pp. 371. Philadelphia: J. B. Lippincott & Co., 1859.

The author of these essays, though a man of decided talent and ability as a writer, and long a teacher of medicine, never published an extended work on any branch of the science of which he was so bright an ornament, and his son has done well to select from his published and unpublished papers, some of the more important, and place them before the public in a form for easy reference.

The volume comprises the following essays, viz:

On the Cryptogamous Origin of Malarious and Epidemic Fevers.
On Animal Magnetism or Vital Induction.
On the Penetrativeness of Fluids.
On the Penetrativeness of Gases.
On a New Practice in Acute and Chronic Rheumatism.

All but one of these Essays have been before the profession for a long time, as monographs, or in the columns of our periodical medical literature, and many will be glad to procure them in their present permanent form. Those especially who remember Dr. Mitchell as the accomplished Professor of the Theory and Practice of Medicine in the Jefferson Medical College, will be glad to possess this memento of their favorite teacher, and their friend.

URINARY DEPOSITS; *their Diagnosis, Pathology and Therapeutical Indications.* By GOLDING BIRD, M. D., F. R. S. Edited by EDMUND LLOYD BIRKETT, M. D., etc., etc. A new American, from the *fifth* London edition. With eighty illustrations on wood, pp. 382. Philadelphia: Blanchard & Lea, 1859. *Price* $1 30.

This work has long been before the profession, who have shown their appreciation of it by calling for *five* editions in London, and two or three in this country.

The forms of urinary disease of which the work treats, are of such grave importance that every practitioner should possess every possible aid in their diagnosis and treatment, and we know of no work which, in so small a space, contains so much that is calculated to aid the practitioner and student in his investigations.

The book is fully illustrated with well executed wood cuts, and is got up in a manner that is creditable to the publishers.

DEFECTS OF SIGHT AND HEARING; *their Nature, Causes, Prevention and General Management,* By T. WHARTON JONES, F. R. S., F. R. C. S., Prof. of Ophthalmic Medicine and Surgery in University College, London, etc., etc. Edited, with additions, by LAURENCE TURNBULL, M. D., Surgeon to the Department of Diseases of the Eye and Ear of the Howard Hospital of Philadelphia, etc. pp. 247. Philadelphia: C. J. Price & Co., 1859. *For sale by Lindsay & Blakiston.*

This little work is calculated to be useful in the management of various affections of the eye and ear, and their prevention. The author is well known as an enthusiastic and successful ophthalmologist, and author of an extended work on the subject. The American editor has made some additions, especially to the fourth part of the work, which treats of affections of the ear.

Editorial.

PRACTICAL PHARMACY AS A PART OF MEDICAL EDUCATION.

In a communication to the *Southern Medical and Surgical Journal,* Dr. Robert Battey calls attention to the importance of a pharmaceutical education for the physician. We are very glad that he has done so. It is high time that the profession was aroused to the importance of this subject. It is one of the crying evils of our present system of medical education, that little or no attention is paid to the subject of practical pharmacy at our medical colleges. In the schools of this city no provision whatever is made to give systematic instruction in botany, or the history, properties, and mode of preparation of drugs. It is true that Mr. Edward Parrish has for some years past kept up a school of practical pharmacy as a private enterprise, of whose advantages a few young men avail themselves every year, most of them with a view of presenting themselves for examination before the Boards

of Examiners of the army or navy, where some knowledge of practical pharmacy is very properly required. Yet, so small is the number of young men who attend Mr. Parrish's lectures, that we believe they are hardly considered remunerative.

This is wrong. Our medical colleges should have professorships, or at least lectureships, of Botany and Practical Pharmacy, and a competent knowledge of these branches should be a requisite for graduation. In these days, when almost everything we eat, drink or wear—when the milk that nourishes the babe, and the medicine that is intended to ward off or remove disease, are alike subject to sophistication, the physician should have some practical knowledge of the qualities and properties of staple articles of food, and of the drugs he uses for the purpose of restoring health, or he surely is not competent to discharge his duties in an intelligent manner, and to serve the community as they reasonably expect to be served.

Our present mode of instruction permits many a man to go out armed with a diploma that represents him as competent to discharge all the duties of the physician, who could not distinguish between ipecac. and jalap, cinchona and canella, colchicum and garlic, digitalis and horehound, if they were presented to him. Much less is he capable of going through with the various pharmaceutic processes, by which these articles are prepared for administration. It is true that the professor of materia medica hurriedly points out the physical characteristics of the various articles of the materia medica while lecturing upon them, but more than this is necessary; the student should be taught to familiarize himself with each article by frequent inspection and handling, comparison with other articles that resemble them in the least, and especially with inert or even deleterious articles resembling them, with which they are often adulterated.

We feel that we cannot sufficiently urge upon the student the importance of becoming acquainted with the physical properties of drugs, their resemblances and differences, and the characteristics of the substances with which many of our most valuable drugs are adulterated, as well as with the proper mode of preparing and exhibiting the various articles of the materia medica. And we feel, too, that, with our present mode of imparting medical knowledge, both in the office of the preceptor and in the medical college, this kind of knowledge is very inadequately imparted. We hope that the day is not distant when our colleges will include *Botany and Practical Pharmacy* as a part of their curriculum of study.

WOMAN DOCTORS AGAIN.

In commenting on the recent action of the Pennsylvania State Medical Society in relation to woman doctors, we have raised a breeze which, considering the state of the weather, is really quite refreshing. A respected correspondent, in another column, takes us to task for our article of last week. He seems to think that it needed backbone. We are sorry that our views are not in accordance with his, but were of course aware, when we penned them, that they would not meet with the concurrence of those who brought the subject before the County and State Societies, and perhaps of a majority of the members of those bodies. But, having views, we felt called upon under the circumstances to give expression to them, and we may say that they have been well received, we know, by many of our readers, and that we believe they are in accordance with those of a large majority of the profession.

We have always felt that it is idle for the profession to pursue every ignis fatuus that arises in its border ground. There are some evils that work out their own cure soonest by letting them alone, and as the public will take the responsibility of thinking and acting for itself, in matters pertaining to our profession—often, it is true, much to its own detriment—we have felt that more in the end would be gained if the profession would spend its time in elevating its own standing in the community, rather than by waging an unequal warfare against the various irregularities that are ever and anon arising. We say unequal, because our opponents—if we elevate them to

that position, can and will use weapons that we would scorn to employ.

Besides, on this question of woman doctors, we labor under the decided embarrassment of admitting them as a fact, every day of our lives, in the use we make of the published works of Boivin and Lachapelle. We have no Index Expurgatorius that will blot them from the literature of medicine, even if we desired to do so.

As to the evil which has been the occasion of these remarks, we never considered it of sufficient magnitude to warrant our declaring war against it, and firmly believe that its continuance will be short or long, in proportion to the degree of prominence given it.

If this were a matter of faith and salvation, or, if it in any way involved the honor of the medical profession; we would speak in unmistakable tones against it, but as it is a mere matter of opinion, and that of a class of people whose opinions on any subject are of little consequence to the medical profession, or any body else, and as the evils, if any, arising from it, are confined to that class of people, we are content to let them enjoy their opinion, while we look calmly on in the consciousness that the evil will soon cure itself.

We are very glad that our code of ethics does not refer to the subject. That is made for all time, we hope, while this is a thing of a day, and the general principles of the former are sufficient to guide honorable members of the profession in dealing with woman doctors, and those who countenance them, as well as with other evanescent evils.

In the present state of human society, we doubt very much whether any good will come of the medical profession attempting to exorcise the evil spirits that prophecy in its name, unless they utterly cast them out by stripping the ass of the lion's skin, as in the case of quack medicines, for instance, by analyzing them, and publishing their formulæ.

AN IMPORTANT WORK ON CALORIC.

We are glad to learn that Lippincott & Co., of this city, have in press, and will soon issue, the second edition of Metcalf's Work on Caloric. The first edition was published by Pickering in London in 1843, and the work immediately took high rank among scientific publications. The author had made arrangements for republishing the work in this country, with additions and corrections, but his health failed, and he died in this city a few years ago, without fully completing the labor of preparing the second edition for the press.

The work is in two volumes, octavo, and is a learned and exhaustive treatise on caloric in all its relations to physics and to organic life, and in its bearing on health, and should be in the library of every physician.

Through the indefatigable exertions of his widow, an intelligent English lady, the work has been completed under the direction of a competent editor, and will soon be ready for sale. Mrs. Metcalfe has undertaken to publish the work by subscription, and has received much encouragement from the profession of this and other cities, and we cordially commend her to the profession of other cities she may visit for the purpose of obtaining subscriptions. Mrs. M. depends, we believe, in great measure, on the proceeds of the sale of this work for the means of support for herself and child.

A more extended notice of the work will appear as soon as it issues from the press.

Correspondence.

Editors of the Medical and Surgical Reporter:

I feel confident that, if you will take the trouble to read over attentively the editorial remarks, having for their caption "*Woman Doctors*," contained in the last number of your journal, you will find them to be less conclusive and sound than you doubtless esteemed them when you penned them. They strike me, and you must bear with me when I say so, as bearing a very close resemblance in style to that species of oratory, with its non-sequences and contradictions, to which the term cant—using the word in its more modern and comprehensive signification—may be very correctly applied.

You profess yourselves to be in favor of an entire repudiation, "a severely letting alone," of the whole sisterhood of female medical practitioners by our profession. You candidly confess that, in your opinion, women mistake their vocation when they devote themselves to the study and practice of medicine, and that when they do so the *best policy* of physicians is to discountenance their stepping thus out of their legitimate line of life—but silently; not that physicians should discuss the question as to the propriety of recognizing females as physicians, and meeting them upon the same footing as male members of the profession, and having arrived at a conclusion adverse to the claims of the female doctors, boldly announce it. This you would on no account have physicians to do. You regret that it has been done by the Pennsylvania State Medical Society, and hope that no other of our Medical Societies will follow her example.

If it be right and proper for the medical profession tacitly to ignore the very existence of women doctors—and such ignoring necessarily implies the refusal on the part of physicians to give countenance and support to the faculties and graduates of female medical colleges, and of female medical practitioners generally—how can it be otherwise than right and proper, and expedient too, for them to openly and unreservedly declare ther intention so to do. As to what would be the most honest and manly course there can be but one opinion.

It would puzzle us to know in what manner the profession could be brought to adopt, *en masse*, the "best policy," of letting "woman doctors" "alone severely," unless, the question, being mooted and decided in our County and State Societies, this decision is openly promulgated.

The admirable code of ethics to which we profess obedience, is silent in respect to the course of conduct to be pursued by medical men in respect to female physicians. The question has only recently arisen, inasmuch as female medical colleges and women doctors had no existence at the time the code was framed.

It is a well known fact, that there are medical men, as well such as acknowledge entire fealty to the code of ethics, as others who are willing to be governed by it just so far as shall not interfere with their own selfish interests, who do not hesitate to meet women doctors in consultation—even such of them as are of extremely doubtful repute. While the great majority of the reputable members of the profession are convinced that such a course is impolitic at least, if it be not decidedly injurious to the best interests of the profession and of the public at large. Now, in view of this discrepency of opinion and practice, inquiry upon inquiry, and from various quarters, had been made, for a decision as to the proper course to be pursued by physicians generally in reference to women doctors, whether they are or are not to be recognized and treated as legitimate members of the medical profession. The Philadelphia County Medical Society, after a deliberate and impartial consideration of the question decided against their recognition, which decision has been endorsed as correct, by the Pennsylvania State Medical Society.

The penny-a-liner may seize upon this very proper action of our County and State Medical Associations "to make capital with a certain class of the community, and as a good text to descant on the bigotry and narrow-mindedness of the medical profession." Let them do so if it seemeth to them good; but whether they do or not, it should have no influence whatever upon the course to be pursued by the medical profession in respect to any question which may call for its action. We trust that the time has arrived, if it was ever absent, when the acts of the medical associations of our country are beyond the control of the entire class of penny-a-liners—that the disinterestedness, the liberality, and public spiritedness of our profession are too well established to cause its members to fear the misrepresentations and sneers of those who, for capital, are ever ready to minister to the depraved tastes of the ignorant and the prejudiced. ***

June 29, 1859.

Periscope.

FOREIGN.

[From the German, by L. ELSBERG, M. D., of N. Y.

(Concluded from p. 278.)

Further clinical remarks on Glaucoma, and glaucomatous diseases; and on the curative effect of Iridectomy; by A. von Graefe.—A year has passed since the illustrious Graefe made his first formal communication on these subjects, and the practitioners all over the world keeping up with the progress of our profession have

watched them since with the intensest interest. What had been contributed by others up to the present time consists in *Jäger's* communication to the *Oest. Zeitsch. f. prakt. Heilk. and Küchler's* case in the *Deutsch Klinik.* Küchler's operation of iridectomy proved successful. Jäger mainly differed from Graefe in theory by denying entirely the dependance of the excavation of the optic nerve on intraocular pressure, (giving as reasons, 1. that it occurred without such pressure; 2. that it did not occur in various affections of the eye where such increased pressure occurred; and 3. that excavation did not retrocede after iridectomy, but often enough proceeded, while yet other ectases retrogressed after the operation;) and in practice, his experience with iridectomy was calculated to modify considerably the favorable prognosis of acute glaucoma, if operated on early, by Graefe. The readers of the REPORTER will doubtless therefore welcome the testimony now presented. Graefe has had sufficient time to watch the cases previously operated on, and to make many new operations; and to the results of Müller's positive pathological demonstrations, and Roser's plausible valve hypothesis, are added Graefe's matured confirmations of his previous experience which has even become in some respects more favorable yet to Iridectomy.

In the prodromic stage, the results of a second series of operations on 10 or 12 persons who were already glaucomatously blind in one eye, were as favorable as with those previously operated on. All the patients regained pupillary motion and a good range of accommodative power. After the operation no retinal ecchymosis arose which usually does arise with operations for acute glaucoma, and though frequently passing away with perfect restitution of function, sometimes occasions permanent indistinctness in peripheral vision. The case cited in Graefe, previous communication has not relapsed, on the contrary the man reads No. 2 of "Jäger's Letters" fluently, and the extent of his visual field is normal.

Those operated upon *during the first stage of acute glaucoma* have without a single exception remained restored to their fullest extent, although most of them have reattended to their previous occupations unrestrictedly. That the operation can hardly be performed early enough, was especially proved in the case of persons whose one eye was operated upon on the first or second, and the other on the fourth or seventh day after commencement of inflammatory symptoms. The central acuteness of sight, especially the eccentric visual power was ⅓ to ½ less on the side last operated on, though previous to the disease the eyes had been equally vigorous. The power of accommodation remained impaired in most cases, especially where changes in the iris to a high degree had occurred. Jäger is right that the operation on one eye could not prevent the occurrence of glaucomatous ophthalmia on the other. (See REPORTER, Vol. II, p. 132.)

In the latter stage of acute Glaucoma, the success of iridectomy varied, but perfect blindness was always prevented. The prognosis becomes unfavorable when the visual field seems narrowed in the form of a slit, particularly where the point of vision is near the boundary of the field of vision, for in spite of beginning improvement and for a time stationary sight, the power of distinguishing objects finally disappeared. The more the weakness of sight is due to the phenomena of pressure and obscuration of the refracting media, the more aid may be expected; but little is to be hoped after organic changes in the optic nerve and retina have occurred. Five weeks after commencement of the inflammation, in a case in which all quantitative sensibility to light was gone, iridectomy yielded but a negative result. Graefe repeatedly insists on the fact that growing worse after remaining stationary for a time is not ascribable to a recrudescence of the glaucomatous process but to the progressive (secondary) atrophy of the optic nerve. The colliculus becomes of a dull waxen appearance, easily distinguishable from its tendinous white gloss in cerebral amaurosis.

In relation to chronic glaucoma.—Graefe has not in his last added anything new. As long as the substantial changes of the retina and optic nerve in the individual cases baffle exact observation (on account of the obscuration of the media) the prognosis can not be accurately determined. Iridectomy remains indicated as long as the least considerable remains of sight exists; sometimes negative results will follow, sometimes temporary improvement, and so on.

As to the theory of the development of glaucoma, Graefe has made the observation, (diametrically opposed to what Jäger uses as a settled fact) that *excavation of the optic nerve in certain cases actually retrocedes after iridectomy.* These cases refer to chronic glaucoma, which after a time had assumed an acute character. In such cases the already little resisting papilla of the optic nerve is excavated by the glaucomatous choroideal inflammation rapidly and to a very great degree, and after the operation the deep cavity may be seen

within a week changing to a shallow depression the bent vessels on the edge being braced and greater displacements compensated and rendered imperceptible. Quite recent cases of glaucoma are unsuitable for such observations because there exists as yet no excavation, and the later stages of the same do not allow the restitution on account of degeneration and atrophy of the nerve-fibres. Two important facts besides the actual retrogression of excavation may be adduced as favoring the correctness of the theory of increased intraocular pressure, viz: the disappearance of the arterial and the synchonic venous pulsation after the operation; and the lessening of far-sightedness, the frequently rapidly increasing presbyopy in glaucoma depending doubtlessly on the decreasing convexity of the cornea. (The reader has of course also compared Müller's and Roser's contributions with his, all militating against Jäger's denial of the influence of intraocular pressure.)

To obtain a clear view of the nature of glaucoma other diseased conditions of the eye must be taken into consideration; viz: traumatic cataract, iritis, iridochoroiditis, staphyloma posticum, hydrophthalmia, and ectatic corneal cicatrices. It has long been known that these abnormal conditions may "become glaucomatous."

Iritis terminating with closure of the pupil is always accompanied by progressive amblyopy, which depends often, it is true, on retinal separation, but often also on excavation of the optic nerve.

In the course of staphyloma posticum besides obscured vitreous body, retinal separation, cataracts, etc., excavation of the papilla of the optic nerve may also be observed, but the cavity is not so striking and sharply marked because the power of resistance of the sclerotic does not in these cases deviate much from that of the optic nerve. The bulb becomes fuller and harder, the pupil more dilated and less active, the cornea insensible, and the field of vision narrows concentrically or laterally. This is easily demonstrable in persons over 50 years old suffering from staphyloma posterius.[1])

Thus, leucoma and staphyloma of the cornea are often attended by weakness of sight and even absolute amaurosis, which cannot be explained by the disease of the cornea alone. The conclusion as to the existence under such circumstances of increased pressure within the bulb is often strengthened by the gradual participation in the forward arching of even firmer corneal cicatrices and the contiguous portion of the sclerotic.

In all these cases therefore, besides employment of mydriatica, paracentesis, and removal of the puffed or displaced lens, Iridectomy will in future be indicated.

[1] A report on *staphyloma posterius*, a knowledge of which has become very important not to the professed ophthalmist alone, but to *every* practitioner—will appear in our next.

Medical News.

The following gentlemen have been appointed vaccine physicians in this city: 1st Ward, Dr. Robert Reyburn; 3d, Dr. H. D. Benner; 5th, Dr. Fisler; 7th, Dr. R. W. Ritchie; 9th, Dr. A. Owen Stillé; 11th, Dr. Geo. B. Lummis; 13th, Dr. Robt. S. Kenderdine; 15th, Dr. E. B. Jackson; 17th, Dr. James W. Roe; 19th, Dr. Edgar Janvier; 21st, Dr. J. K. Uhler; 23d, Dr. D. M. Veal.

We sincerely regret to learn that Dr. John Neill has resigned the position he has filled so creditably, of surgeon to the Pennsylvania Hospital. The vacancy has been filled by the election of Dr. Edward Hartshorne, a gentleman whose qualifications to perform the duties of the office are well known.

The newly appointed Boards of Guardians of the Poor and of Health of this city, will organize next Monday. They each consist of twelve members, three each having been appointed by the Supreme and District Courts, and by the Court of Common Pleas, and by Councils. From the known character and standing in the community of the gentlemen who have been appointed on these Boards, it is reasonable to suppose that the interests of the public will be served.

ANSWERS TO CORRESPONDENTS.—*Dr. S., Kenton, Ohio.*—For the information you desire see the REPORTER No. 131 for April 23d, page 85, a copy of which is herewith forwarded.

Dr F., Darlington, Md.—The article you use is considered the best here. There would seem, therefore, to be no remedy for the difficulty you complain of but to purchase little and often. We will, however, look further into the matter.

MARRIAGES.

GOOD—HOUTZ—On Thursday, June 9th. at the residence of the bride's father, by Rev. S. T. Lowrie, D. R. Good, M. D., of Altoona, Pa., to Miss Eliza B., daughter of D. Houtz, M. D., of Alexandria, Huntingdon Co., Pa.

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A.	" 13, " 20 1 oz. Fluted Prescription Vials,	7 75
	" 7, cont. 24 1 oz. Gr'd Stopper Bottles, with pockets,	11 50
A.	" 11, " 24 1 oz. Fluted Vials,	8 75
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A.	" 13, " 20 1 oz. Fluted Vials,	7 75

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No. 6,	"	27	" " 4 "		10 50
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REFERENCES.

George W. Norris, M. D., Surgeon to the Pennsylvania Hospital.
Henry H. Smith, M. D., Professor of Surgery, University of Pennsylvania.
H. L. Hodge, M. D., Professor of Obstetrics, University of Pennsylvania.
Samuel D. Gross, M. D., Professor of Surgery, Jefferson Medical College.
Joseph Pancoast, M. D., Professor of Anatomy, Jefferson Medical College.
S. Littell, M. D., Surgeon Will's Hospital.
E. Hartshorne, M. D., " "
A. Hewson, M. D., " "
D. Hayes Agnew, M. D., Surgeon to Philadelphia Hospital.
R. J. Levis, M. D. " " "
Isaac Hays, M. D.
P. B. Goddard, M. D. 118